Executive Summary

Communication failure is a leading source of adverse events in health care. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) identified communication failure as a pivotal factor in over nearly 70% of more than 3,000 sentinel event reports since 1995. As of March 2006, nearly 80% of more than 6,000 Root Cause Analysis reports to the VA National Center for Patient Safety (NCPS) involve communication failure as at least one of the primary factors contributing to adverse events and close calls. In the IOM report, *To Err is Human: Building a Safer Healthcare System*, teamwork training to improve communication is recommended for health care organizations, "…establish team training for personnel in critical care areas … using proven methods such as the Crew Resource Management (CRM) training techniques employed in aviation."

NCPS began developing a Medical Team Training (MTT) program in 2003 designed to introduce communication tools to professionals working in VA facilities with the expectation they will integrate these tools into the clinical work place. Our program is organized into three important components: 1) application, preparation, and planning for the Learning Session and MTT project; 2) Learning Session in the VAMC; and 3) follow-up data collection and support of participating VAMCs for one year.

As of April 2006, 19 facilities are participating in the program involving clinical units, such as the OR (11), ICU (4)[1], Med-Surg unit (1), Ambulatory Clinics (3), and ED (1) (see Appendix A). Each Learning Session is held in a VA Medical Center for a full day of interactive dialogue, faculty role play, participant exercises and teaching films of clinical vignettes produced by NCPS demonstrating CRM applications in health care. The *Safety Attitudes Questionnaire (SAQ),* developed and validated by the Johns Hopkins Quality and Safety Research Group, is completed by each participant prior to commencing the session and repeated one year later. The SAQ measures attitude and behavioral changes expressed in six factors: safety climate, teamwork climate, job satisfaction, working conditions, perceptions of management, and stress recognition. Results of comparative data analysis will be submitted to each participating facility.

To participate in the MTT program, each VA facility makes a commitment to an MTT project which is organized by a multidisciplinary Change Team of VAMC staff with NCPS guidance. Each MTT project must involve briefings and debriefings to be initiated in the clinical unit targeted by leadership within days after the Learning Session. Briefings and debriefings provide the necessary context for the application of CRM tools. In the clinical context, a briefing is a conversation facilitated by a team leader to establish a shared understanding of the work and management of patient care in the health care environment. A debriefing is a similar conversation to examine perspectives on a recently shared experience.

MTT faculty will provide follow-up support of each participating VAMC through monthly group conference calls and individual quarterly semi-structured interviews for a minimum of one year. The theory of this program is that implementation of MTT communication principles in health care delivery will improve patient outcomes and staff job satisfaction, which will be tested by a robust program evaluation.

[1] One VAMC included both the OR and the ICU staff

Appendix A – Participating VAMCs and Clinics in the MTT program

VAMC	Learning Session Date	Clinical Unit(s)	MTT Activities After Learning Session (Reports from follow-up interviews and conference calls)
1) Des Moines, IA	9/10/03	Operating Room	**Briefings and Debriefings in the OR** Report: streamlined instrument case packs; working on reduction of delays in first case of the day
2) Detroit, MI	9/24/03	Surgical ICU	**Patient Centered Multidisciplinary Rounds in the ICU** Report: nurses more comfortable asking questions and participating in decision making; decreased s
3) Buffalo, NY	10/30/03	Medical ICU	**Patient Centered Rounds with residents and nursing staff** Report: reduction of inappropriate ICU admissions; improved understanding of daily patient goals
4) Boston, MA	11/10/03	Operating Room	**Briefings and Debriefings in the OR** Report: streamlined instrument case packs; improved understanding of personnel and equipment nee
5) Black Hills, SD	11/13/03	Med-Surg Unit	**Patient Centered Multidisciplinary Rounds and using CRM tools with staff** Report: improved staff-to-staff communication
6) Jackson, MS	11/17/03	Medical ICU	**Administrative Briefings integrated with Patient Centered Briefings** Report: improved communication among staff; reduction of urinary tract infections; improved house
7) Houston, TX	9/13/04	OR	**Pre-op Briefings in the OR** Report: improvement in measures of communication between surgeons and anesthesiologists; increa administration within 60 minutes of incision; increase in DVT prophylaxis before induction of anest cancelled surgical procedures due to findings from pre-op briefing.
8) Atlanta, GA	3/4/05	OR	**Briefings in the OR** Report: conducting debriefings on Gen. Surgery service
9) Bay Pines, FL	5/6/05	OR	**Debriefings in the OR** Report: Debriefing 100% of surgical cases – approximately 300 per month; scanning debriefing info record; improved communication – as measured by the MTT questionnaire – between surgeons and comfortable verbalizing concerns during surgical procedures.
10) Nashville, TN	5/13/05	OR	**Briefings and Debriefings in the OR** Report: Briefing and Debriefing all surgical cases; problems identified during Debriefings are addre in surgical cases receiving antibiotics within 60 minutes of incision; one case was cancelled due to c the pre-op briefing
11) Long Beach, CA	8/5/05	OR	**Debriefings in the OR** Report: Debriefings after Vascular Surgery cases; plan roll out of the Debriefing program to the enti time
12) Honolulu, HI Tripler Hospital Oahu Clinic	8/17/05	Prim. Care Clinics	**Administrative Briefings in the Clinics** Report: Multidisciplinary Administrative Briefings in outpatient clinics; "Rules of Conduct" implem communication between clinical staff
13) Honolulu, HI Tripler Hospital Clinics from Kauai, Maui, Kona, Hilo	8/18/05	Prim. Care CBOCs[2]	**Administrative Briefings and Debriefings in the Clinics** Report: Outpatient clinics report conducting "huddles" each morning to discuss the day's events. Th staffing issues, cross coverage, and review patients coming in, as well as debriefing the day before. awareness of issues before they happen, improved staff moral and improved efficiency.

[2]VA Community Based Outpatient Clinics

14) Fargo, ND	9/7/05	OR, ICU	**Patient-Centered Multidisciplinary Briefings in the ICU; Briefings & Debriefings in the OR** Report: Multidisciplinary rounds on each patient in the ICU weekly; Briefings and Debriefings on 5 11/05
15) Minneapolis, MN	9/9/05	OR	**Debriefings in the OR** Report: Debriefing surgical cases led by circulator RN in the OR
16) St. Louis, MO	9/20/05	ED	**Improving Transfers to the ED** Report: tool was developed to improve information transfer between outpatient clinics and the Emer
17) Las Vegas, NV	9/29/05	Prim. Care Clinics	**Administrative Briefings in the Clinics** Report: Multidisciplinary Administrative Briefing in the outpatient clinics
18) West Haven, CT	10/28/05	OR	**Briefings in the OR** Report: developing briefing guides for sub-specialty surgical services; improving surgical schedulin delays
19) Providence, RI	12/2/05	OR	**Pre-op Briefings and the institution of the MTT "Rules of Conduct" in the OR** Report: they have stared briefings and debriefings on Gen Surg and Urology services